



Medical School Hotline

The Role Of Accreditation in Medical Education

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The John A. Burns School of Medicine of the University of Hawaii is preparing for reaccreditation, a process that the school must undergo at least every seven years. The reaccreditation process is a major institutional commitment that requires thousands of hours of preparation and extensive documentation. Contemplating the magnitude of the investment required to negotiate successfully the accreditation process, one might ask, "What is the intrinsic value of accreditation?" and "What role does it play in medical education?" Accreditation is mandatory for the 125 medical schools chartered in the United States, but not required for the operation of foreign based schools. In fact, the Kigezi International School of Medicine of Uganda and the Ross University School of Medicine in Dominica recently sought to establish branch campuses in the United States. Neither of these medical schools is accredited. Ross University recently abandoned plans to open a new campus in Casper, Wyoming, intended to enroll somewhere between six hundred and a thousand students annually. Such an influx of students, associated faculty, and staff required to educate them would have provided a significant economic boon to the community of Casper, Wyoming, but what is problematic about the establishment of such an unaccredited medical school is that in order to practice medicine in the United States, individuals must qualify and pass a series of licensing examinations administered by the National Board of Medical Examiners. To qualify, one must have graduated from a U.S. accredited school of medicine or be certified by the Educational Commission for Foreign Medical Graduates.

There are a number of reasons why accreditation is of importance. First, the quality of foreign medical schools is highly variable. This is evidenced by the fact that half of the graduates of foreign schools seeking licensure in the United States fail to pass the licensing examinations. In contrast, less than 5% of graduates of U.S. medical schools fail to pass these examinations. Thus, accreditation promotes a consistent standard of quality across the spectrum of U.S. medical education ensuring that the vast majority of physicians produced by the U.S. system are competent.

Second, requiring U.S. based medical schools to obtain accreditation has the effect of placing rational limits on the number of physicians in practice in the United States. Allowing unaccredited medical schools to open in the United States could potentially flood the physician marketplace with new graduates seeking to establish themselves in practice, thus driving the rapidly escalating cost of healthcare even more quickly. For example, if even half of the 1,000 students a year Ross intended to enroll had passed the licensure examination, the "successful" class size of 500 would far exceed the size of even the largest U.S. medical school.

If accreditation is in fact desirable, what does it consist of and what

role does it play in the healthcare system of our state and nation? The history of accreditation provides some instructive lessons for today's situation. In the years prior to 1900 there were hundreds of medical schools in operation in the United States. Many were small diploma mills that guaranteed a degree to any individual who could pay the money required for tuition. A healthcare system relying on this type of medical education, with no external standards available to insure quality, resulted in medical care that was highly variable, and on the whole, of dubious quality. Around the turn of the century both the American Medical Association and the Association of American Medical Colleges began reviewing medical schools to examine the quality of the medical education. In fact, by 1910, the American Medical Association's Council on Medical Association issued a publication, "The Essentials of an Acceptable Medical College", which listed the suggested standards for medical schools. These included a curriculum of four years duration with two years of basic science instruction and two years of clinical work, supervision of the school by a dean, a required minimum core faculty of graduates from recognized medical colleges with ability as teachers and researchers and adequate facilities for instruction. The existence of standards of this type helped to bring about a consolidation of the number of medical schools in the United States since many of the schools of questionable quality and intent were closed. Those that remained improved their educational programs.

In 1942, the AMA and the AAMC established the Liaison Committee on Medical Education (LCME) aimed at improving medical education through the establishment of standards. In the early 1980s the LCME became the national authority for the accreditation of medical schools, as recognized by the Council on Post Secondary Accreditation and the U.S. Department of Education. This recognition led to the addition of more accreditation standards in the '80s. Through the '90s, additional standards were added in response to national calls for reform in medical education and, even today, the LCME is actively refining and adding to the accreditation standards.

The accreditation process consists of three parts. The first is the compilation of a large amount of standardized factual data on all facets of medical school operation. This is referred to as the educational database, that forms the basis of the report. The database is designed to give the LCME a comprehensive picture of the state of affairs existing at each medical school at the time of accreditation. In the second part, a medical school conducts an institutional self-study, an analysis of the school's strengths, weaknesses and opportunities for improvement. The self-study is designed so that a large number of faculty and students participate in the work of analysis.

The third component of the accreditation process is a site visit by a team of medical school faculty from across the United States. These individuals are dispatched to the school undergoing accreditation for a five-day visit with the purpose of clarifying questions raised by the materials submitted by the school. The site visit team meets with a wide variety of individuals at the host institution, including administrators, faculty, students and the dean. During the site visit, the team writes a report that focuses on the accreditation standards and the school's compliance with them. The team also prepares a list of strengths and weaknesses of the medical school, which are shared with the dean and the University president at an exit interview.

The site visit team is a recommending body and takes no formal action on accreditation. The LCME reviews the report of the site visit team and makes an accreditation decision. The decision can range from full and unconditional accreditation for seven years to probation for serious violations of the accreditation standards.

The accreditation standards consist of nearly 156 separate requirements.⁵ Of these, approximately 50 apply to teaching, learning and evaluation, i.e. the educational process. A recent initiative of the Association of American Medical Colleges called the Medical Education Standards and Assessment Project examined a number of salient issues in the accreditation process, including the meaning and application of medical accreditation standards, the importance and validity of medical accreditation standards and the influence of accreditation on educational change in U.S. medical schools.

Accreditation requires that medical schools specify their educational objectives, develop resources and programs to accomplish those objectives and track whether those objectives are being achieved through the implementation of evaluation systems. Accreditation is a quality assurance mechanism for medical education in the United States. It requires medical schools to undertake periodic external and internal self evaluations, a process that spurs continual adaptation and evolution on behalf of those institutions. Several reports have concluded that accreditation has had a positive effect on the education of physicians in the United States.^{6,7} The LCME claims that its accreditation standards encourages educational reform, fosters the adoption of pedagogical methods more likely to cultivate habits of self assessment and life long learning, creates greater coherence of instruction across the basic and clinical science years and leads to stronger institutional oversight and accountability for the curriculum.⁸

In conclusion, the process of accreditation of medical schools in the United States has led to an educational system for physicians without peer in the world. This claim is substantiated by hard evidence; 97% of students admitted to United States medical schools subsequently graduate, 95% of graduates are accepted into residency programs, 95% of residents complete their programs and 94% of students and residency graduates pass licensing exams on the first try.² Although the accreditation process is complex, burdensome, resource intensive and time consuming, it does appear to be fostering high quality medical education. For those spending many hours preparing for JABSOM's upcoming reaccreditation, it is of comfort to know that the process has value both as an internal quality control mechanism and an external endorsement of the quality of the education provided. Thus, continuation as a fully accredited medical school is an important priority worthy of the efforts expended.

References

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situation. If the nurse responds in the manner as hoped, the desired outcome has been achieved. However, if the nurse doesn't recognize the serious nature of the comment, then the ability to "save face" is achievable by saying "only joking." The skill for nurses is in learning to listen beyond the laughter, whether the person addressing them is a peer, patient, family member, or doctor.

Physiological effect: In addition to the functions of humor, the physiological effect of humor is identified as a benefit. Most nurses are able to describe at least one negative physiological effect of stress: muscle tension, cold hands, headaches, gastrointestinal disturbances, and many more. While researchers have spent years identifying the negative effects of stress on body systems, they are now looking at the therapeutic effects of humor and laughter on the human body. These include decreased muscle tension, deeper respirations, and positive increases in the immune system.

As nurses practice to improve their abilities to use and appreciate humor, they also enhance their skill. "Humor appreciation involves responding to humor produced by others or being a good audience. On the other hand, humor production involves thinking of things on your own to amuse yourself or others," says Michelle Newman, PhD. When using humor as a coping mechanism, one cannot always count on being able to find an external focus of amusement. "Of the two, humor production is the more portable skill," says Newman and adds, "From the standpoint of coping, it seems to me to be less important whether you can amuse other people than whether you can amuse yourself." The implication for nurses is that while they may gain benefits from humor when enjoying it passively, there are even more benefits in being active participants by producing a humorous state of mind for themselves.

Because everyone's sense of humor is unique, the techniques used to create humor must be highly individualized. The methods need not be flamboyant to be effective. For example, some nurses might be comfortable wearing a small decorative pin with an amusing picture or statement on it, particularly at seasonal times. Colorful clothing with festive accents might be an option if dress codes do not forbid. Some nurses are subtle, wearing Looney Tunes socks or Mickey Mouse jewelry while others walk the halls wearing a red sponge nose or carrying a rubber chicken! Posting cartoons and illustrations can brighten up any nursing unit. Sharing jokes, stories, or embarrassing moments are other ways to generate laughter. Humor baskets, carts and humor rooms are means of creating a more humorous environment.

Many nurses may refrain from using the skill of humor on the grounds that it is not "professional." Humor is not the equivalent of "goofing off." Indeed, it is important for nurses to maintain high standards and high expectations on their units and to take their work seriously. It is also important for nurses to be able to take themselves lightly. Sad is the nurse who cannot learn to separate the two—and that is no joke.